STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF HEALTH CARE SERVICES
CERTIFICATION & LICENSING

PLAN OF CORRECTION

Facility Name:	Date:
Plan of Correction due date:	

This *Plan of Correction* is submitted in response to the Report of Inspection/Investigation and *Notice of Violation* issued by the Department and dated ,

SECTION I

Please describe in detail each action that will be taken to correct each of the violations outlined in Section I above (7AAC 10.9610(a)(1)). Attach additional sheets if necessary:

SECTION II

Please describe in detail each measure that will be taken, or change that will be made, to ensure that each of the violations outlined in Section I above do not recur (7AAC 10.9610 (a)(2)). Attach additional sheets if necessary.

SECTION III

Please describe in detail how your facility will monitor each corrective action described in Section II above to ensure the violation is cured and will not recur (7AAC 10.9610 (a)(3)). Attach additional sheets if necessary.

SECTION IV

Please identify the date on or before which each violation identified in Section I above will be cured (7AAC 10.9610 (a)(4)). Attach additional sheets if necessary.

SECTION V

Has each violation listed in Section I above been corrected prior to the submission of this Plan of Correction?

☐ Yes ☐ No

SECTION VI

I certify that the contents of this Plan of Correction and information provided with it are true, accurate, and complete.

Printed Name of Person Completing Report

Title

Signature of Person Completing Report

Date

SECTION VII – FOR DEPARTMENT USE ONLY

Yes ☐ No ☐ Plan of Correction Accepted?

Date

Community Care Licensing Specialist I